Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
1204 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380-5010

Respondent Name
BITUMINOUS CASUALTY CORPORATION

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2705-01

MFDR Date Received
April 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid according to allowed amount. We have appealed 3 times."

Amount in Dispute: $5,306.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reimbursement was calculated based upon the contracted rate under the CorCare II WC PPO network rates. Under that contact [sic] reimbursement is based upon 60% of the eligible billed charges, not the total billed charge."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2010	Outpatient Hospital Services	$5,306.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Contracted/Legislated Fee Arrangement Exceeded
   - B15 – Procedure/Service is not paid separately
   - GP – Service delivered under OP PT care plan
   - RD7 – Multiple Procedure/1st Procedure
   - RD8 – Multiple Procedure/2nd Procedure (50%)
   - RD9 – Multiple Procedure/3rd or Subsequent (50%)
   - W1 – Workers' Compensation State Fee Schedule Adj
   - 59 – Allowance based on Multiple Surgery Guidelines
   - 97 – Charge Included in another Charge or Service
   - GO – Service delivered under OP OT care plan
   - R79 – CCI: Standards of Medical/ Surgical Practice
   - RN – Not paid under OPPS: services included in APC rate
   - 168 – No additional allowance recommended
   - 351 – Priced according to Contract Agreement
   - 193 – Original payment decision maintained
   - ORC – See Additional Information

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Contracted/Legislated Fee Arrangement Exceeded," and 351 – "Priced according to Contract Agreement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 13, 2013, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. No documentation was found to support that the insurance carrier, Bituminous Casualty Corporation, had been granted access to the contracted fee arrangement. The notice does not include the name, physical address, or telephone number of the persons given access to the network's fee arrangement with the health care provider as required by §133.4(d)(2)(A). The notice does not include the start date and any end date during which the insurance carrier had been given access to the contracted fee arrangement as required by §133.4(d)(2)(B). The notice letter is not addressed to the provider and is not dated. No documentation was found to establish time of notification in accordance with §133.4(f). The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and

supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 96374 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $37.44. This amount multiplied by 60% yields an unadjusted labor-related amount of $22.46. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $19.30. The non-labor related portion is 40% of the APC rate or $14.98. The sum of the labor and non-labor related amounts is $34.28. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $34.28 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.01217, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $182.47 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $34.28. This amount multiplied by 200% yields a MAR of $68.56.
- Per Medicare policy, procedure code 96375 may not be reported with procedure code 20680 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted information finds no documentation to support the use of this modifier. Separate payment is not recommended.
- Procedure code 96376, date of service April 15, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15
- Procedure code 36415, date of service April 15, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 80048, date of service April 15, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15

- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93
- Procedure code 85025, date of service April 15, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93
- Procedure code 73550 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.94. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $23.15. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $41.11. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $41.11. This amount multiplied by 200% yields a MAR of $82.22.
- Procedure code 20902 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $2,141.60. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,284.96. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $1,104.29. The non-labor related portion is 40% of the APC rate or $856.64. The sum of the labor and non-labor related amounts is $1,960.93. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,960.93 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.696192, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $10,438.29 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.264. This ratio multiplied by the billed charge of $10,438.29 yields a cost of $2,755.71. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,960.93 divided by the sum of all APC payments is 67.37%. The sum of all packaged costs is $3,527.97. The allocated portion of packaged costs is $2,376.71. This amount added to the service cost yields a total cost of $5,132.42. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,700.79. 50% of this amount is $850.40. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,811.33. This amount multiplied by 200% yields a MAR of $5,622.65.
- Procedure code 20680 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0022, which, per OPPS Addendum A, has a payment rate of $1,576.49. This amount multiplied by 60% yields an unadjusted labor-related amount of $945.89. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $812.90. The non-labor related portion is 40% of the APC rate or $630.60. The sum of the labor and non-labor related amounts is $1,443.50. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate.

The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $721.75 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.256244, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $3,841.97 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $721.75. This amount multiplied by 200% yields a MAR of $1,443.50.

- Procedure code 27599 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0129, which, per OPPS Addendum A, has a payment rate of $111.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $67.04. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $57.61. The non-labor related portion is 40% of the APC rate or $44.69. The sum of the labor and non-labor related amounts is $102.30. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $51.15 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.01816, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $272.28 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $51.15. This amount multiplied by 200% yields a MAR of $102.30.
- Procedure code G0237, date of service April 15, 2010, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0077, which, per OPPS Addendum A, has a payment rate of $27.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.41. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $14.10. The non-labor related portion is 40% of the APC rate or $10.94. The sum of the labor and non-labor related amounts is $25.04. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $25.04 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.00889, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $133.29 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $25.04. This amount multiplied by 200% yields a MAR of $50.08.
- Procedure code 97012, date of service April 15, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $14.49. This amount divided by the Medicare conversion factor of 36.8729 and multiplied by the Division conversion factor of 54.32 yields a MAR of $21.35
- Per Medicare policy, procedure code 97110, date of service April 15, 2010, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 97116, date of service April 15, 2010, may not be reported with procedure code 97530 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted information finds no documentation to support the use of this modifier. Separate payment is not recommended.

- Per Medicare policy, procedure code 97530, date of service April 15, 2010, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted information finds no documentation to support the use of this modifier. Separate payment is not recommended.
- Per Medicare policy, procedure code 97001, date of service April 15, 2010, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 97530, date of service April 15, 2010, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 97003, date of service April 15, 2010, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94760, date of service April 15, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1790 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2271 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690, date of service April 15, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1650, date of service April 15, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120, date of service April 15, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0379 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8002; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0604, which, per OPPS Addendum A, has a payment rate of $57.92. This amount multiplied by 60% yields an unadjusted labor-related amount of $34.75. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $29.86. The non-

labor related portion is 40% of the APC rate or $23.17. The sum of the labor and non-labor related amounts is $53.03. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $53.03. This amount multiplied by 200% yields a MAR of $106.06.

- Procedure code 96372, date of service April 15, 2010, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of $13.23. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $23.50. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $23.50 divided by the sum of all S and T APC payments of $2,816.65 gives an APC payment ratio for this line of 0.008343, multiplied by the sum of all S and T line charges of $14,993.40, yields a new charge amount of $125.09 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $23.50. This amount multiplied by 200% yields a MAR of $47.00.

4. The total allowable reimbursement for the services in dispute is $7,609.38. This amount less the amount previously paid by the insurance carrier of $12,015.49 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	May 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.